



Sri Ramachandra Medical Centre **Department of Pediatric Urology**

The Department of Pediatric Urology, Sri Ramachandra Medical Center is pleased to announce the admission to Fellowship Programs in Pediatric Urology

Course Details: Fellowship in Pediatric Urology

- **Qualification** : M.Ch/ DrNB in Pediatric Surgery or Urology
- **Number of Seats** : 1
- **Course Duration** : 12 months
- **Course Fee** : Rs. 2,00,000/- (Rupees two lakh only)
- **Stipend** : Rs. 80,000/- per month (Rupees Eighty thousand only)
- **Attendance requirement for examination** : 90 %

Those interested may kindly submit the prescribed application form to below @ address.

- Last Date for submitting Application 15th April 2025
- Interview will be 2nd week May 2025
- Course commences 1st July 2025

For downloading application – [Click on Fellowship in Pediatric Urology](#).

@ Address for Communication:

Senior Consultant: Dr. Ramesh Babu Srinivasan
paediatricurology@sriramachandra.edu.in

Sri Ramachandra Medical Centre,
No. 1 Sri Ramachandra Nagar, Porur, Chennai 600116

For further information if any please call 044-45928500 Ext No: 539

Email Id : fellowship.mc@sriramachandra.edu.in

Website : www.sriramachandra.edu.in



SRI RAMACHANDRA MEDICAL CENTRE

Porur, Chennai - 600 116.

APPLICATION FORM FOR “FELLOWSHIP IN PEDIATRIC UROLOGY” 2025-26 Session

Affix your latest
colour Passport
size photograph
here.

(Note: Please fill in each column in your own handwriting and put a tick mark (✓) wherever necessary and strike off the portion not applicable. Incomplete application form will be rejected summarily).

1. a) Name of the candidate (AS PER PROVISIONAL / DEGREE CERTIFICATE IN BLOCK LETTERS)	:	Dr.
b) Expand the initials	:	
c) Complete address (with District, State & PIN CODE) to which communication is to be sent	:	
d) Phone No. with STD Code	:	Residence : Mobile : E-mail ID :
2. a) Father's Name Contact Details	: :	Mobile : E-mail ID :
b) Mother's Name Contact Details	: :	Mobile : E-mail ID :
c) Husband's Name Contact Details	: :	Mobile : E-mail ID :
3. Sex	:	Male <input type="checkbox"/> Female <input type="checkbox"/>

4. a) Date of birth and age	:	DD/MM/YYYY	Age:
b) Place of birth, District and State	:		
5. Qualifying examination passed. (Self attested Photocopy of the Degree certificate and Statement of Marks of all examinations to be enclosed)	:	Name of PG Degree : University Regn. No : Month : Year :	
6. a) Name and address of the Medical College where qualified	:	UG PG	
b) Whether the College and course is recognized by the Medical Council of India.	:	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; padding: 5px; text-align: center;">Recognised</div> <div style="border: 1px solid black; padding: 5px; text-align: center;">Not Recognised</div> </div>	

7. a) Papers Presented :

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b) Papers Published :

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8. a) Whether the candidate has passed all the examinations in the first attempt	:	PG : Yes / No MBBS: Yes / No						
b) If no, how many attempts were made to pass	:	<table border="1"> <tr> <th>Course</th> <th>No. of attempts</th> </tr> <tr> <td>MBBS</td> <td></td> </tr> <tr> <td>PG</td> <td></td> </tr> </table>	Course	No. of attempts	MBBS		PG	
Course	No. of attempts							
MBBS								
PG								
9. Details of Permanent Registration with the Medical Council incorporating PG qualification (Photocopy to be enclosed)	:	State : Regn. No.: Date :						

DECLARATION BY THE CANDIDATE

I declare that the information furnished by me herein are true and correct. In case any information furnished herein is found to be incorrect or any document is found to be not genuine, I agree to forego my claim for admission and abide by the decision of the Sri Ramachandra Medical Centre authorities.

I further declare that I have read the prospectus furnished with the application form fully and understood the contents therein clearly and I hereby undertake to abide by the conditions prescribed therein. I undertake to abide by the Rules and Regulation of Sri Ramachandra Medical Centre.

Place:

Signature of the Candidate

Date:

Name: